STATEMENT OF CONSIDERATION RELATING TO
907 KAR 1:055

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 1:055 was requested and held; however, no comments were made at the hearing.

(2) The following individuals submitted written comments regarding 907 KAR 1:055:

Name and Title	Organization/Agency/Other Entity
Joseph E. Smith, CEO,	Kentucky Primary Care Association

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 1:055:

Name and Title	Organization/Agency/Other Entity
Lee Guice, Director	Division of Policy and Operations, Department for Medicaid Service
Neville Wise, Deputy Commissioner	Department for Medicaid Services
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Reimbursement for Services in a Hospital

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Major policy goals of the Public Health Service Act, Patient-Centered Medical Home Model, and the Affordable Care Act are to establish a medical home for primary care and ensure continuity of care. If OB/GYN services cannot be reimbursed to a FQHC, FQHC look-alike, or RHC, recipients will be pushed away from their primary care medical home for no good reason. Some provider will be reimbursed for the care, why should this not be the FQHC, FQHC look-alike, or RHC? Studies have shown that FQHC, FQHC look-alike, or RHC reduce costs of inpatient care.

http://c.ymcdn.com/sites/www.mpca.net/resource/resmgr/cost_efficiency_study_2014/Cost_effective_ES_online.pdf

"The current practice of reimbursement for inpatient hospital services has been in place for years. Based on this longstanding practice, more than five FQHC and RHC have established OB/GYN programs. In 2014, Kentucky's FQHCs and RHCs performed more than 4,000 deliveries and obstetrical surgeries. It is projected that they will perform more than 5,400 deliveries and obstetrical surgeries in 2015."

"Is the purpose of the reimbursement change to push physicians associated with a FQHC or RHC to obtain a separate Medicaid provider number and bill separately? If so, why complicate billing and increase overhead for both the providers and the payors? Further, it would increase the cost of care because the physicians who formerly were billing through the FQHC's would have to bill Medicaid independent of the FQHC and would therefore not be covered by the Federal Tort Claims. The increase in overhead for OB/GYN services due to private medical malpractice premiums would be substantial."

"Ending inpatient reimbursement will mean significant disruption for clinics that have already established OB/GYN programs and for recipients who are likely to have family members receiving care at the FQHC, FQHC look-alike, or RHC. For example, consider a pregnant mother with children who are treated by a FQHC pediatrician. If the FQHC cannot bill for inpatient hospital, will she be forced to go to another physician for OB services and to the FQHC for pediatric services. Where is the continuity of care both for her, her already born children, and for the new born once it leaves the hospital?"

"In many of Kentucky's most medically underserved areas, only the FQHC or RHC is available to provide OB/GYN services. Where are the patients of these programs to go to obtain OB/GYN services? By failing to reimburse for inpatient service, the Department will be forcing some recipients to travel unreasonable distances for care. For example, PrimaryPlus is the sole OB/GYN provider in Maysville and is the only primary care provider doing OB surgery in a 45 mile radius."

"Even in other areas that are not so medically underserved and where other OB/GYN services available, will they willing to treat Medicaid patients? If so, there is no assurance that these services will continue to take Medicaid patients."

"Another significant area of concern would be the geriatric population served by RHCs and FQHCs, who would no longer be able to have their primary care provider follow their care while they are in the hospital. Again, this would be in direct conflict with the goals of continuity of care and a primary care medical home."

"For a number of Critical Access Hospitals the RHC providers are the only hospital staff."

"One clinic is poised to take over the entire primary care group in one community currently run by the hospital. The clinic will staff the hospital and run a hospitalist

program."

"Other states reimburse for inpatient care, Ohio for example reimburses on a fee for services system. Why is Kentucky taking the step of foreclosing inpatient care by FQHCs and RHCs?"

"The original PPS rate setting process was approved by CMS for KY. What has changed?"

"Basically this provision appears to be contrary to current efforts to create Medical Homes and Patient Center Medical Home."

(b) Response: The Department for Medicaid Services (DMS) is amending the administrative regulation to establish that it will reimburse for services provided by an FQHC, FQHC look-alike, PCC, or RHC in a hospital to a recipient if the recipient has previously received a service from the FQHC, FQHC look-alike, PCC, or RHC at the FQHC's, FQHC look-alike's, PCC's, or RHC's location.

(2) Subject: Base Year

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 1.(4) (page 2, line 13) — Given the definition of 'base year' could a provider's base year change if hours of operation change? Would this provision tend to create barriers to PCP efforts to increase access to PC to prevent unnecessary use of the ER?"

"Section 1. (13)(c)1. (page 3, line 17) — Same as question 1"

(b) Response: The base year will not change.

DMS is revising the definition of "base year" as follows in an "amended after comments" administrative regulation to also address the problem of some entities enrolling in DMS and receiving an interim PPS rate and either filing a cost report several years later or never filing a cost report. Doing so results in DMS paying a rate which cannot be linked to an entity's reasonable cost and exposes DMS to potential recoupment from the Centers for Medicare and Medicaid Services. The revised definition is as follows:

"(4) 'Base year' means the first full fiscal year following the effective date of an FQHC's, FQHC look-alike's, or RHC's enrollment in the Medicaid program:
(a) In which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation as designated by the FQHC, FQHC look-alike, or RHC; and
(b) Not to exceed twenty-four (24) months past the effective date that the FQHC, FQHC look-alike, or RHC was enrolled with the department."

(3) Subject: MGMA Report

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 1.(21) and (22) (page 6, line 14 and following) — The use of the MGMA reports is contrary to trends in healthcare, particularly primary care, that emphasize quality of care and outcomes. The emphasis of MGMA is on productivity and it continues the "treat 'em and street 'em" approach to care that has not proved to be beneficial to either patients or to the healthcare system."

(b) Response: DMS needs an objective and nationally published and recognized tool to assist in determining reasonable compensation. DMS is open to suggestions for future consideration.

(4) Subject: Desk review and audit

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 3. (4) (c) (page 13, line 5) — The section refers to adjustment of a final PPS rate following a desk review or audit. What would trigger a desk review or audit? Can they be initiated by the Department at any time it deems appropriate? The Cabinet should develop and publish criteria which would trigger an audit or desk review post final rate establishment."

(b) Response: DMS has the right to review or audit any provider's information at DMS's discretion including random sampling. As the Medicaid program is funded by state and federal taxpayer monies the fact that provider records and information are subject to audit is an integral component of being a Medicaid provider. Acknowledging that provider records and information are subject to audit is consistent with the agreement each provide signs upon enrolling in the Medicaid program.

(5) Subject: Final PPS rate

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 4. (3) (f) 2. (page 17, line 4) — The section prohibits request of a paid claims listing until 14 months after the end of a fiscal year. Does this mean that the final PPS rate will not be established until such time?"

(b) Response: Correct. The fourteen (14) month period is necessary to allow for the lag in claims processing as providers have up to twelve (12) months to submit claims and additional time may be needed to correct given claims. The accuracy of the claims data

is critical in establishing an accurate final PPS rate.

(6) Subject: Reimbursement not to exceed upper limit

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 8. (3) (page 20, line 5) — The section references a limit on reimbursement not to exceed the upper limit of federal payment under 42 C.F.R. 447.304. Clarification is requested as to the meaning of this provision."

(b) Response: The upper payment limit for an FQHC, FQHC look-alike, or RHC would be their respective PPS rate based on reasonable costs.

(7) Subject: Adjustment over time for APM

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 9. (1) (b) (page 20, line 13) — The section sets the APM at 125% of the Medicare upper payment limit for RHC in effect on September 30, 2014. There is no provision for adjustment over time. It is suggested that language be added to state that the APM will be adjusted as CMS adjusts the upper payments to RHC's."

(b) Response: DMS had to secure approval of its alternative payment methodology from the Centers for Medicare and Medicaid Services (CMS) and DMS spent considerable time with CMS negotiating an acceptable APM rate. CMS does not have to approve any APM, but DMS was attempting to assist RHCs, FQHCs, or FQHC look-alikes whose final PPS rate was very low and the APM was the mechanism available to do So. The APM as stated in the administrative regulation – 125% of the Medicare upper payment limit for RHCs in effect on September 30, 2014 – is what CMS ultimately agreed to approve without any added inflation or related increase.

Related to the APM, DMS is adding an option via an "amended after comments" administrative regulation for any FQHC, FQHC look-alike, or RHC that has an interim PPS rate in effect as of November 1, 2015 to receive the APM as an interim PPS rate if it elects to do so.

(8) Subject: Cost report for interim rate for a chance in scope

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 10.(8)(c) 4.(page 24, line 15 to 23) — The section provides for the submission of a cost report for an interim rate change for a change in scope. This seems to be redundant and unnecessary given that a MAP 100501 will have been prepared and

submitted."

(b) Response: DMS agrees that a universal cost report is not needed to establish an interim change-in-scope PPS rate; however, a universal cost report is utilized along with the MAP 100501 to establish a final change in scope PPS rate. DMS is revising the language accordingly in an "amended after comments" administrative regulation to reflect this.

(9) Subject: MCO Reimbursement

(a) Comment: Joseph E. Smith, CEO of the Kentucky Primary Care Association, stated the following:

"Section 14 (page 29, line 2) — Clarification of the intent and meaning of Section 14 is requested."

(b) Response: Managed care organizations are not required to adopt DMS's reimbursement for services. Rather, each MCO's reimbursement to a given provider is a matter between the respective MCO and the respective provider based upon whether agreement the two (2) parties have. DMS is not a party to this agreement. The intent of Section 14 is to address this – that MCOs are not required to reimburse as DMS does for services.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:055 and is amending the administrative regulation as follows:

Page 2
Section 1(4)
Line 14
After "program", insert a colon, a return, and "(a)".

Line 16
After "operation", insert the following:
as designated by the FQHC, FQHC look-alike, or RHC; and
(b) Not to exceed twenty-four (24) months past the effective date that the FQHC, FQHC look-alike, or RHC was enrolled with the department

Page 14
Section 4(2)(a)2.
Line 3

After "the", insert "designated base".
Delete "first full fiscal".

Lines 4 and 5
After "year", delete the remainder of the subparagraph except for the semi-colon.

Page 15
Section 4(3)(a)
Line 5
After "RHC's", insert "designated base".
Delete "first full fiscal".

Lines 5 to 7
After "year", delete the remainder of the subparagraph except for the period.

Page 16
Section 4(3)(d)1.
Lines 7 and 8
After "RHC", insert the following:
as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation
Delete the following:
based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010

Page 16
Section 4(3)(d)2.
Lines 12 to 14
After "RHC", insert the following:
as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation
Delete the following:
based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010

Page 17
Section 4(3)(f)3.
Lines 9 and 10
After "RHC", insert the following:
as it pays primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation
Delete the following:
based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010

Page 19
Section 7(1)(b)2.
Line 6
After "a", insert a colon, a return, and "a.".

Line 7
After "1:626", insert the following:
; or
b. Given physician's service, the department shall reimburse for the service pursuant to 907 KAR 3:010.
3. The department shall reimburse a rate equal to seventy-five (75) percent of the rate it pays a physician pursuant to 907 KAR 3:010 for a physician's service that:
a. Does not exist on the current Kentucky-specific Medicare Physician Fee Schedule; and
b. Is provided by an APRN or physician assistant

Page
Section 9(2)(a)
Line 17
Before "(2)(a)", insert the following:
(c) An FQHC, FQHC look-alike, or RHC that had an interim PPS rate prior to November 1, 2015 may request the APM as an interim PPS rate until the FQHC's, FQHC look-alike's, or RHC's final PPS rate is established.

Page 23
Section 10(8)(a)2. and 3.
Lines 15 to 17
After "[~~(b)~~]", delete the following:
A projected Universal Cost Report containing twelve (12) months of projected cost report data for the interim PPS rate change;
3.

Page 23
Section 10(8)(a)4.
Line 19
Renumber this subparagraph by inserting "3." and deleting "4."

Page 24
Section 10(8)(c)1.b.(ii)
Line 6
After "establish", insert "an".
Delete "a PPS".

Page 24
Section 10(8)(c)4.
Line 18

After "contained in the", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment
Delete "Universal Cost Report".

Page 24
Section 10(9)(a)
Line 21
After "a", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

Line 22
After "data", insert the following:
for the first full fiscal year end after
Delete "beginning with".

Page 25
Section 10(9)(b)
Line 3
After "department the", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

After "data", insert the following:
for the first full fiscal year end after the effective date of
Delete "period associated with".

Page 25
Section 10(9)(c)1.
Line 6
After "Review the", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

Line 8
After "the", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

Page 26
Section 10(9)(e)2.
Line 4
After "a", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

Page 26
Section 10(9)(e)2.b.
Line 8
After "the", insert "FQHC".
Delete "FHQC".

Page 27
Section 10(9)(g)1.
Line 6
After "a", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

Page 27
Section 10(9)(g)1.b.
Line 12
After "receiving the", insert the following:
completed MAP 100501, Prospective Payment System Rate Adjustment and

Page 28
Section 11(3)
Line 6
After "look-alike,", insert "PCC,".

After "hospital", insert the following:
unless the FQHC, FQHC look-alike, PCC, or RHC has previously, any time prior to the hospital admission, provided a service to the recipient at the FQHC's, FQHC look-alike's, PCC's, or RHC's location